

State Employee Benefits Committee
Monday, May 16, 2014 at 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on May 16, 2014, at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, Director, OMB, SBO
Faith Rentz, Deputy Director, OMB, SBO
Alexis Bryan-Dorsey, OMB
Kelly Callahan, Office of the Treasury
David Craik, Pension Office
Emily Cunningham, Lt. Governor's Office
Dawn Davis, OMB, SBO
Karin Faulhaber, PHRST
Patricia Griffin, SEBAC Chair & Courts
Dawn Guyer, OMB, Financial Operations
James Harrison, DSEA-R
Claudia Hughes, DSEA-R
Katherine Impellizzeri, Aetna
Michael Kelleher, University of DE
Geoffrey Klopp, DOC

Dave Leiter, DHSS
Michael Morton, Controller General
Jennifer Mossman, Highmark DE
Casey Oravez, OMB, Financial Operations
Andrew Kerber, DOJ
Karol Powers-Case, DRSPA
Rebecca Reichardt, OMB
Kimberly Reinagel-Nietubicz, CGO
Sandy Richards, AFSCME Retirees
Paula Roy, Roy Assoc.
Jim Testerman, DSEA-R
Jennifer Vaghn, DOI
Valerie Watson, Department of Finance
Crystal Webb, DHSS

Introductions/Sign In

Director Visalli called the meeting to order at 2:00 p.m. Anyone who had public comment was invited to sign-in and any others wishing to comment would be given the opportunity at the end of the meeting. Introductions were given around the room.

Approval of Minutes

Director Visalli requested a motion to approve the minutes from the March 10, 2014 SEBC meeting. Controller General Morton made the motion and Ms. Valerie Watson seconded the motion. Upon unanimous voice vote the minutes were approved.

Director's Report – Brenda Lakeman

Ms. Lakeman reported that Open Enrollment began May 12. There have been 2,037 employees (33,822 employees) who have logged on to eBenefits to date. There have been two health fairs with 300 attendees. To date, the Statewide Benefits Office has received approximately 550 calls and the Pension Office has received 1,500 calls have been received. Most callers have only minor questions. We are reminding them to complete the Coordination of Benefits form if they cover a spouse. Open Enrollment ends May 28.

Group Health Financials - handout

Ms. Oravez reviewed and discussed the February and March 2014 Fund and Equity Reports. The health fund balance for the end of February was reported at \$24.5M and decreased to \$14.9M by the end of March. April is not yet available. Medicare Part D payments owed as of January 31, 2014 total \$10.4M; due to be received at the end of this calendar year. There was an additional Express Scripts payment in March. Director Visalli reminded the Committee that they voted to utilize surplus funds to pay expenses for the current year and the decline in the balance is expected.

Revisions to Group Health Insurance Program's – Eligibility and Enrollment Rules (handout)

Ms. Rentz reviewed changes to the Group Health Insurance Program Eligibility and Enrollment Rules effective July 1, 2014. These changes were sent to members on to review in advance of the meeting. A summary of the revisions follows below. A motion will be needed to approve the changes.

Revision to 1.00 – correction of eligibility and coverage to eligibility and *enrollment*.

Revision to Chapter 2, Item 2.01: Suggested language, last paragraphs of 2.01 modified to read:

A Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age, upon enrollment *in other health coverage*, any time *other* health coverage changes, or upon request by the Statewide Benefits Office or the State's plan administrator. Reason: The Adult Dependent Coordination of Benefits Policy expires July 1, 2014, however, a child/ren may be covered by each parent, one parent through the State and the other through his/her employer, requiring the State's plan to pay as primary or secondary. The State's plan administrator requests the State member to complete the Dependent Coordination of Benefits form to adjudicate claims accordingly. The change also clarifies that the form needs to be completed if enrolled in other health coverage, not simply upon enrollment in the State's health coverage.

Revision to Chapter 2, Item 2.02: Suggested language for Item 2.02 to read:

Eligible dependent child/ren covered under the health insurance plans of both parents (*one of whom must be employed by a group not participating in the State Plan*) will be primary to the parent's plan whose birthday is the first to occur during the calendar year. In the event the parents' birth dates are the same, the dependent child will be primary to the parent with the longest employment service. In the event birth dates and length of service are the same, the dependent child will be primary to the mutual choice of the parents. Reason: To clarify that both parents who participate in the State Plan may not cover the same dependent child/ren.

Mr. Klopp asked why both parents, when both were participating in the State plan, could not cover the same dependent child. Director Visalli explained that only one parent is permitted to cover the same child as primary. In situations where one parent is covered through an employer not participating in the State plan, both parents are permitted to cover the same dependent and it is incumbent upon the State employee to complete a carrier Coordination of Benefits form to inform the State plan's carrier of which coverage should pay as primary and which as secondary.

Revision to Chapter 2, add Item 2.03 - New suggested language to read:

Eligible dependent child/ren whose parents are divorced or are not living together and not married will be primary to the plan of the parent with custody or primary to the plan of the spouse of the parent with custody unless a Court or Administrative Order defines one parent as responsible for the child/ren's health care expenses or health care coverage and if so, that parent's plan will be primary. If a Court or Administrative Order states that both parents are responsible for the child/ren's health care expenses or health care coverage or that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child/ren the provisions of Eligibility and Enrollment Rule 2.02 shall apply. If there is no Court or Administrative Order allocating custody or responsibility for the child/ren's health care expenses or health care coverage the provisions of Eligibility and Enrollment Rule 2.02 shall apply. Also see Eligibility and Enrollment Rule 4.10.

Please note, the addition of the above language as Eligibility and Enrollment Rule 2.03 requires the renumbering of former Eligibility and Enrollment Rule 2.03 to 2.04, etc. Reason: To clarify a dependent child/ren's level of coverage when parents are divorced; not married and living apart; joint custody; when a Court or Administrative Order is in place; or when both parents have responsibility in accordance with Court or Administrative Order.

Revision to Chapter 3, Item 3.01 - Suggested language to read:

Coverage of an eligible regular officer or employee (*eligible for State Share*) and his/her eligible dependents will become effective *on the date of hire or on the first of any month up to the first of the month when eligible for State Share provided the employee submits a signed application within 30 days of the first of the month when coverage becomes effective. Refer to Eligibility Table for specific coverage date options for employees who elect coverage when eligible for State Share.*

Premiums are not pro-rated *for employees who elect coverage on their date of hire which is not the first day of the calendar month.* Reason: Provides eligible regular officer or employee opportunity to enroll in coverage to be effective on the date of hire or the beginning of any month prior to receiving State Share to defer penalty of Affordable Care Act.

Revision to last paragraph of Chapter 3, Item 3.01 - Suggested language to read:

Deletion of first paragraph in its entirety.

A Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age, upon enrollment *in other health coverage*, any time other health coverage changes, or upon request by the Statewide Benefits Office or the State's plan administrator. Reason: The Adult Dependent Coordination of Benefits Policy expires July 1, 2014, however, a child/ren may be covered by each parent, one parent through the State and the other through his/her employer, requiring the State's plan to pay as primary or secondary. The State's plan administrator requests the State member to complete the Dependent Coordination of Benefits form to adjudicate claims accordingly. The change also clarifies that the form needs to be completed if enrolled in other health coverage, not simply upon enrollment in the State's health coverage.

Revision to Chapter 3, Item 3.05 - Suggested language to read:

Eligible employees or pensioners who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire, *or first of any month up to* their date of eligibility for State Share (*See 3.01*) or their date of retirement may not join the State Plan until the next Open Enrollment period (usually May), unless the employee or pensioner meets the requirements of Eligibility and Enrollment Rule 3.06. Reason: To support changes to Eligibility and Enrollment Rule 3.01.

Revision to Chapter 3, Item 3.09, second paragraph - Suggested language to read:

Each eligible regular officer, employee, or pensioner may elect to enroll under a separate contract, but no regular officer or employee or eligible pensioner may be enrolled more than once under the State Plan. *Eligible dependents may not be enrolled more than once under the State Plan and can be enrolled under either parent unless the parents cannot agree in which case enrollment shall meet the requirements of Eligibility and Enrollment Rules 2.02 and 2.03.* Reason: To clarify enrollment of dependents cannot be under more than one plan and which parent can enroll the child dependent.

Revision to Chapter 4, Item 4.01 - Suggested language to read:

An eligible employee who elects to be covered on his/her *date of hire or on the first of any month prior to the employees eligibility for State Share* may change health insurance (medical) coverage when the employee first becomes eligible for the State Share payment. (Examples: (1) An employee who at hire enrolls in the "First State Basic" plan may change to "Comprehensive PPO" (or another optional coverage) when beginning State Share contribution, without waiting for the next open enrollment period. (2) An employee who at hire enrolls for "Employee" coverage may change to "Employee and Child/ren", "Employee and Spouse", or "Family" coverage when he/she begins to receive State Share, without waiting for the next open enrollment period). The employee who elects coverage to dental and/or vision coverage on his/her EMPLOYMENT COVERAGE DATE may not make changes to dental and/or vision coverage until the next open enrollment period unless the employee meets the requirements of Eligibility and Enrollment Rule 3.06. Reason: To support changes to Eligibility and Enrollment Rule 3.01.

Revision to Chapter 4 , Item 4.03 IMPORTANT NOTES - Suggested language to read:

Deletion of first paragraph in its entirety.

A Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment *in other health coverage*, any time *other* health coverage changes, or upon request by the Statewide Benefits Office *or the State's Plan Administrator*. Reason: The Adult Dependent Coordination of Benefits Policy expires July 1, 2014, however, a child/ren may be covered by each parent, one parent through the State and the other through his/her employer, requiring the State's plan to pay as primary or secondary. The State's plan administrator requests the State member to complete the Dependent Coordination of Benefits form to adjudicate claims accordingly. The change also clarifies that the form needs to be completed if enrolled in other health coverage, not simply upon enrollment in the State's health coverage.

Revision to Chapter 4, Item 4.10 – Additional suggested language to read:

Also see Eligibility and Enrollment Rules 2.02 and 2.03 for Dependent Child/ren Coordination of Benefits determination.

Reason: To add reference to other applicable Eligibility and Enrollment Rules.

Revision to Chapter 10, 10.01 c – Suggested language to read:

The Dental and Vision Plans' effective date is always the first of the month and not on *date of hire or date of qualifying event* as for the health plan. Reason: To clarify that enrollment in dental is always on first of the month whether due to hire or qualifying event.

Revision to Appendix A, State of Delaware Group Health Insurance Program Eligibility Table - Suggested language to read:

In column designated as Coverage State Date (Employee pays the full cost) provides the *Start Date, and first of any of the following three months prior to employee receiving State Share*. Reason: To support changes to Eligibility and Enrollment Rule 3.01.

Ms. Rentz asked if there are any questions. There were none. Director Visalli stated she would allow for Public Comments before the motion.

Disability Insurance Program Rules and Regulations – Substantive Revisions (handout)

Ms. Lakeman reviewed changes to the Disability Insurance Program Rules and Regulations – Substantive Revisions effective July 1, 2014. These changes were sent to members on to review in advance of the meeting. A summary of the reason for the revision and the suggested language (in purple) follows below. A motion will be needed to approve the changes.

Ms. Lakeman stated revisions to the Disability Insurance Program are needed through the course of numerous questions received and to explain further as to “clarify” or “define” to improve the understanding of the DIP Rules as utilized by the Benefit Reps. DIP has been in place since 2006. A motion will be needed to approve:

Section 2.0 - Added language to the **Definitions** section of the Rules & Regulations document to clarify what an “appeal” is. The definition we are proposing is referenced below: “*“Appeal” is the action you can take pursuant to 29 Del.C. §5258 if you disagree with a coverage decision made by the DIP insurance carrier and/or third party administrator (Administrator) selected to administer and/or insure the program by the Committee pursuant to 29 Del.C. §5254 and/or*

the Appeals Administrator from the Statewide Benefits Office and/or the Hearing Officer from the Office of Management and Budget and/or the Committee.”

Section 2.0 - Added language to the **Definitions** section of the Rules & Regulations document to clarify who “Less Than Twelve Month Employees” are. The definition we are proposing is referenced below: “**“Less Than Twelve Month Educational Employees”** are those employed by School Districts, Charter Schools, the Department of Education, University of Delaware, Delaware State University and Delaware Technical & Community College whose normal working period is a school year or semester which is less than 12 months in duration per calendar year. “Less Than Twelve Month Educational Employees” are not defined or categorized by their length of employment.”

Section 5.3 - To help reduce the cost of administering the DIP, we recommend eliminating the Human Resources requirement of sending the initial employee communication via certified mail return receipt requested and allowing the communication to be sent via USPS regular mail along with an “Employee Acknowledgement” that must be signed and returned to the Human Resources office by the employee within 5 days of receiving the communication.

Section 5.3 - Recommended new language to read:

Employees are required to immediately report all absences from work to their supervisor and are required to stay in contact with their supervisor and Human Resource office during all absences from work. For specific reporting time frames, merit employees should refer to the Merit Rules. Non-merit employees should refer to their employing organization’s leave policy. All requested documentation must be provided. Supervisors are required to immediately report an employee’s absence from work to their Human Resource office. *The Human Resources office must send a letter to the employee no later than the fifth calendar day of absence from work to remind the employee of their STD claim filing requirement in the event the employee expects to be out of work for at least the length of the elimination period. It is the employee’s responsibility to promptly acknowledge receipt of the communication from their Human Resources office by signing and returning an “Employee Acknowledgement” to their Human Resources office within 5 days of receiving the letter from the Human Resources office.”*

Director Visalli commented 48 hours is a short time to give employee to mail letter; suggested 5 days with no opposing comments. Ms. Lakeman will update Section 5.3 from 48 hours to 5 days.

Section 9.0 - Added additional language to the Leaves section of the DIP Rules & Regulations clarifying a discretionary rule for the employing organization.

9.1.1.1 If the claim is not in an approved status by the exhaustion of the calendar day elimination period due to reasons outside of the employee’s control, the employing organization shall have discretion to pay the employee accrued annual and/or sick leave until the employee’s STD claim is approved. If the STD claim is approved, the employing organization must reconcile the employee’s leave record.

9.1.1.2 At the discretion of the employing organization, employees who are appealing an STD determination and have not returned to work or whose STD claim is still under review by the DIP insurance carrier and/or Administrator and/or the Appeals Administrator from the Statewide Benefits Office and/or the Hearing Officer appointed by the State Employee Benefits Committee, may be paid accrued annual and/or sick leave until the STD claim is approved or extended. If the STD claim is approved or extended, the employing organization must reconcile the employee’s leave record.

Section 9.2.1 - Non Merit Employees - explains the appeal situation. Human Resources can use their accrued leave or not while waiting for appeal to go through.

9.2.1.1 If the claim is not in an approved status by the exhaustion of the calendar day elimination period due to reasons outside of the employee’s control, the employing organization shall have discretion to pay the employee accrued annual and/or sick leave until the employee’s STD claim is approved. If the STD claim is approved, the employing organization must reconcile the employee’s leave record.

9.2.1.2 At the discretion of the employing organization, employees who are appealing an STD determination and have not returned to work or whose STD claim is still under review by the DIP insurance carrier and/or Administrator and/or the Appeals Administrator from the Statewide Benefits Office and/or the Hearing Officer appointed by the State Employee Benefits Committee, may be paid accrued annual and/or sick leave until the STD claim is approved or extended. If the STD claim is approved or extended, the employing organization must reconcile the employee's leave record.

There was a short discussion on why the Human Resources office may use their own discretion when allowing the employee to use sick or annual leave. Director Visalli explained that the HR office is more in tune with their own employees and therefore it's more appropriate for them to make those decisions.

Section 11.4 - The street address for the Office of Management & Budget Haslet Armory was changed in 2013 from "122 William Penn Street, Suite 301" to "122 Martin Luther King Jr. Blvd. South". We have included the new address in Section 11.4 of the DIP Rules & Regulations.

Section 12.3 - Changes to include a timeframe for the employing organization to provide the opportunity for the employee to escrow leave accruals and to add the Transitioning to LTD documents for the purpose of benefit elections while on LTD. Suggested language:

"Six weeks prior to the commencement of LTD benefits, the employing organization will provide the employee with Transitioning to LTD documents for the purpose of escrowing leave accruals for a 6 month period and for benefit elections for while on approved LTD. See subsection 9.1.10.1 for complete description of escrowing leave."

Section 20.0 Return to Work (RTW) – 20.1 - Added the letter (a) which was inadvertently left out as there are two sections (a) and (b) of Del. C. § 5257.

20.1 Pursuant to 29 Del.C. §5256(5), a contract exists between the Committee and the Statewide Benefits Office for the purpose of the administration of the DIP, including but not limited to determination of an individual's ability to return to work by the RTW Coordinator pursuant to 29 Del. C. § 5257 (a) and (b).

Director Visalli asked if there were any questions. There were none.

SEBAC Comment

Members of the SEBAC committee had no comment.

Public Comment

Ms. Karol Powers-Case, DRSPA and Mr. Sandy Richards, AFSCME Retirees signed the Public Comment sheet; however, stated they did not have any comments or questions.

Mr. David Leiter thanked everyone for their hard work. He also asked if it would be possible for the Committee to consider an option where a newly hired employee who needed to enroll upon hire in health coverage and pay the full cost could set up a payment arrangement to pay the premiums during the 90 day State share waiting period over a 12 month period. Ms. Rentz drew attention to existing language in the Group Health Program Eligibility and Enrollment rules that allowed an employee to change plans when they became eligible for State share. This would allow a new employee to enroll in the lowest cost plan and/or tier upon hire and change their health plan election when their State share became effective.

Ms. Claudia Hays expressed confusion over the word "agency" in the rules and wanted to know to whom the DIP rules apply. Ms. Lakeman explained that "agency" means Merit Agency and Ms. Rentz further verified that the DIP rules applied to all Merit Agencies and School Districts. The DIP does not apply to Non-Payroll groups, such as the City of Dover, etc.

Ms. Kelly Callahan questioned whether the Statewide Benefits Office was concerned with consistency across the state, whether some agencies were applying the DIP rules differently than other agencies. Ms. Lakeman confirmed that the DIP rules have been in practice and the updates were being added to clarify the processes. Director Visalli commented that these were pro-employee changes which would allow payment during any waiting periods. Ms. Leslie Ramsey added that there may be external circumstances or situations that may affect the timing of physician's providing documentation and this will help eliminate gaps in pay.

Other Business

Director Visalli asked for a motion to approve the Revisions to Group Health Insurance Program's – Eligibility and Enrollment Rules as listed above and per the handout. Ms. Pat Griffin made the motion and Controller General Michael Morton seconded the motion. The motion passed with a unanimous voice approval.

Director Visalli asked for a motion to approve the Disability Insurance Program Rules and Regulations – Substantive Revisions as listed above and per the handout. Ms. Valerie Watson made the motion with the change from 48 hours to 5 days in Section 5.3 and Controller General Michael Morton seconded the motion. The motion passed with a unanimous voice approval.

Director Visalli commented the next SEBC meeting is scheduled for Friday, June 27, 2014 and asked those present to watch for changes as the June & July meetings may be combined.

Director Visalli asked for a motion to adjourn the meeting at 2:54 p.m. Ms. Emily Cunningham made the motion and Controller General Michael Morton seconded. With unanimous voice approval the motion carried.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB